ANNEX N (REPORTS AND PRODUCTS)

1. SITUATION

a. The Influenza Pandemic Threat: Refer to Annex B (Disease Intelligence).

b. Mission and Intent of Higher and Supporting Organizations: Refer to Base OPLAN.

c. Environment: Refer to Annex B (Disease Intelligence).

2. MISSION.

CDC employs specific reporting processes to receive and disseminate integrated influenza pandemic-related information throughout CDC during crisis situations.

3. EXECUTION

a. Concept of Operations.

An influenza pandemic response will require a high level of preparation, anticipation, flexibility, and coordination across the entire reporting spectrum. Accurate reports will be key to the achievement of situational awareness and successful implementation of CDC's comprehensive response to the influenza pandemic. The Incident Management System (IMS), coordinated from the Director's Emergency Operations Center (DEOC), will be the conduit for information to and from federal, state, local and tribal agencies, field teams, the Incident Manager, and DHHS. The Plans Section will provide the daily Incident Action Plan (IAP) and other reports to the Department of Health and Human Services (HHS) Secretary's Operations Center (SOC) and other federal agencies in accordance with applicable plans or as otherwise required. All reports provided to the HHS SOC will be cleared by the Incident Manager with appropriate input from subject matter experts if required prior to distribution.

b. Report and Product Processes.

Refer to Appendix 1 (Reports and Products Matrix).

Overall responsibility for all reports and products rests with the Incident Manager (IM). The IM will establish the timing, approve the contents of all reports and products, and retains the authority to direct resources to accomplish these important processes.

1) **Incident Action Plan (IAP):**

The IAP is intended to provide an update to the incident management staff on what has happened in the last 24 hours and focus the staff on tasks/objectives to accomplished during the upcoming 24-hour period When the DEOC is activated and in the response mode, the Chief of Plans is responsible for gathering information and assembling the IAP. The IAP is the primary incident management document and will normally cover a 24-hour operational period, usually 1700-1700. The IAP will include all appropriate maps, epidemiological graphs, synopsis of media stories, etc Classified reports will be briefed and maintained within the Sensitive Compartmented Information Facility (SCIF). During events in which the DEOC is not activated a Situation Report (see ???) will be prepared, rather than the IAP.

2) **Director's Morning Summary:**

The Director's Morning Summary will be focused on updating the Director and CC Directors regarding the current situation, objectives, planning assumptions, activities that have occurred and the most up-to-date information possible. This daily briefing uses the Incident Action Plan as the source document for much of its contents. The Director's Morning Summary will be chaired by the IM. Additional attendees will be the JIC Lead, Chief Health Officer, OPS Chief and others as required and identified by the IM. The principle briefer for this update will be the Situational Awareness chief or designee. The Director's Morning Summary will include relevant portions of the Finance, Logistics, Operations, Planning (FLOP). The Director's Morning Summary should occur NLT 0900.

3) **Director's Afternoon Update Summary:**

This briefing mirrors the earlier Director's Morning Summary in format and purpose, but will be concise and include only those key developments or updates that have occurred since the earlier Director's Morning Summary briefing, including relevant portions of the FLOP. The Director's Afternoon Update Summary should occur NLT 1800.

4) **Situation Reports:**

Situation Reports summarize significant developments for quick reference of all CDC personnel responding to a pandemic event . Situation Reports will normally be prepared on a

daily basis, at the end of the work day, or at the same time each day. Normally these will not include detailed analysis, but will be quick snapshots of key happenings. Importantly, these will be transmitted to the field so that all deployed CDC personnel will be aware of these major events and be able to place their own work in the perspective of the overall effort. The Plans Chief is responsible for preparing the Situation Reports, with key input from the Operations Chief. During events in which the DEOC is not activated a Situation Report will be prepared, rather than the IAP.

5) **Spot Reports:**

Spot reports are alerts to decision-makers regarding fast-breaking developments and should be issued on an urgent basis during a pandemic crisis. Spot reports will be submitted to the IM for approval before dissemination. They will be brief in the interest of time, and generally restricted to a quick who, what, when, where, why, and how format, with minimal, analysis. In most instances there will be Spot Report follow-up analysis in the subsequent Director's Morning Summary or Afternoon Update Summary.

6) **Executive Decision Brief:**

The purpose of the decision brief is to provide the Director a forum in which to make a key decision. The brief is focused on the specific decision and uses the Executive Decision Support Memorandum as the foundation for discussions. Discussion among leaders and input is key to the briefing. The briefing should always conclude with the request for a decision from the Director.

7) **Long Term Analyses:**

The primary purpose of the Long Term Analysis is to provide a wider more detailed context to CDC leadership on fast-moving events while helping those dealing with the day-to-day crisis maintain situational awareness. While these reports will also address breaking events in a pandemic, they may focus on broader or longer term implications of the event.. Long Term Analyses could be prepared either at the request of senior CDC executives or on the initiative of analysts with access to clarifying information. In all cases, the IM will monitor and supervise the process.

8) Travel Briefings:

A Travel Briefings are provided to CDC personnel traveling into suspected infected areas anywhere in the world. The briefing provides information concerning individual risk mitigation actions before, during and importantly after the travel to an infected area. The briefings are inputted by appropriate IMS agencies, with IM oversight. Personnel will be debriefed upon their return to update these reports for future staff deployments, and to obtain information for use in other disease intelligence products. It is particularly critical that these briefings be current, reflecting the latest information available from all sources.

9) Media Updates:

The JIC will provide public health information updates daily including breakdown of daily news media calls into to the Department of Media Relations some evaluation of key messages being used by the media, and potential media issues for the daily IAP. JIC should provide this report to the IM NLT 1600 hours daily.

10) Surveillance Data Reporting:

State Epidemiologists and SA Section Chief will report latest epidemiological information to the IMS Planning Section for inclusion in the IAP, NLT 1300 hours.

11) Field Reports:

Field report templates are designed to provide information to the IM and CDC Staff on a daily basis concerning field operations where CDC personnel have been deployed. Field Reports will be submitted to the IM and CDC Staff NLT 1300 hours.

c. Distribution.

1) The Incident Action Plan (IAP) will be reproduced in sufficient copies and provided to all supervisory personnel at the IMS Section, Branch and Unit Leader levels. Because of CDC's unique assets, information sources, and scientific expertise, the IAP will also be a valuable document for distribution to HHS/SOC. IAP reports provided to the HHS/SOC will be cleared by Incident Manager and applicable subject matter experts prior to distribution. The original IAP must be retained in the Documentation Unit.

2) The Director's Morning Summary briefing will be directed primarily toward supporting the Director and key advisers in their decision-making process, and in supporting their ability to carry out their daily duties and future planning in a well-informed manner.
3) The Afternoon Update Summary will be directed in a similar manner as the Director's Morning Summary.
4) Situation Reports will generally be given the widest distribution. All CDC personnel involved in combating the influenza pandemic worldwide should receive a copy, including in the field personnel. All Situation Reports provided to the HHS/SOC will be cleared by Incident Manager and applicable subject matter experts prior to distribution.
5) Spot Reports will go to CDC executive leadership. In addition, they will receive as wide a distribution as possible within CDC especially among personnel dealing with the crisis. All Spot Reports provided to the HHS/SOC will be cleared by the Incident Manager and applicable subject matter experts.
6) Executive Decision Support Briefs, because they are more narrowly focused by their nature, will normally be accorded a more restricted circulation, to the target audience, as well as to policy makers. Their wider dissemination should be only on a need to know basis. Executive Decision Support Memorandums will generally be accorded the same distribution as Executive Decision Support Briefs.
7) Long Term Analyses should be provided wide distribution within CDC and other USG policy makers in public health matters.
8) Travel Briefings are provided to all CDC personnel deploying to deal with pandemic-related events prior to their deployment to the field.
9) Media Updates are provided Media Updates are provided to public media outlets, including the internet, for the purpose of keeping the general public updated on public health information.
10) Surveillance Data Reporting information will be provided to the IMS Planning Section NLT 1300 hours daily.

11) Field Reports will be provided to the IM and CDC Staff (IMS Planning Section) NLT 1300 hours daily.

d. Tasks to Subordinate Organizations.

Refer to Annex C (Operations).

e. Coordinating Instructions.

See Appendix 1 (Reports and Products Matrix) to Annex N

4. SUPPORT SERVICES

Refer to Annex I (Support Services).

5. MANAGEMENT AND COMMUNICATIONS

Refer to Annex K (Information Management).

APPENDIXES.

1. Reports and Products Matrix
2. Sample Reports and Products

APPENDIX 1 (REPORTS AND PRODUCTS MATRIX) TO ANNEX N

Reports will be submitted to the IMS Planning Section by email, fax or phone.

Table 15: CDC Reports and Products Matrix

Item	Lead	Purpose	Time	Internal to:	External to:
DCIR to Director	IM	Ensure the Director is in receipt of any & all DCIR reports	Immediate	CDC Director	
Incident Action Plan (IAP)	IMS Plans	Establishes goals and objectives for the next operational period and captures the daily activities	Daily	CDC Leaders	HHS/SOC
Director's Morning Summary	IM	Briefing to keep the Director & CDC decision makers informed on all important developments	Daily, NLT 09:00.	Director & CDC/CIOs	
Afternoon Update Summary	IM	Update Briefing to the Director and CDC decision makers on breaking PANFLU-related events	Daily, NLT 18:00	Director & CDC/CIOs	
Situation Reports	IMS	Summarizing significant developments for quick reference of all CDC staff	Daily, End of Day	CDC Staff & Field	HHS/SOC
Spot Reports	IMS	Alert items CDC leadership & staff should be aware of	Immediate	Director & CDC/CIOs	HHS/SOC
Executive Decision Support Brief	IM	Provide detailed information on a development in an event	As Needed	Director & CDC/CIOs	
Executive Decision Support Memo	IM	Written format for a Decision Support Brief	As Needed	Director & CDC/CIOs	
Long Term Analyses	IM	Focuses on broader or long-term implications of an event	As Needed	Director & CDC/CIOs	
Travel Summaries	IMS	For informing CDC staff being deployed abroad	As Needed	CDC Staff	
Media Updates	JIC	Provide Public Health Information	NLT 1600	CDC Staff	Public Media
Surveillance Data Reporting	State / SA	Provide latest epidemiological State information for IAP input	NLT 1300	IMS Planning	
Field Reports	Field Teams	Provide Daily Update on Field Operations to IM & CDC Staff	NLT 1300	CDC Staff & Field	

APPENDIX 2 (SAMPLE REPORTS AND PRODUCTS) TO ANNEX N

Following is a listing of Sample Reports and Products:

Tab A	Incident Action Plan (IAP)
Tab B	Director's Morning Summary
Tab C	Afternoon Update Summary
Tab D	Situation Report
Tab E	Spot Report
Tab F	Executive Decision Support Brief
Tab G	Executive Decision Support Memorandum
Tab H	Long Term Analysis
Tab I	Travel Summary
Tab J	Media Update Template
Tab K	Surveillance Data Reporting Template
Tab L	Field Report Template

NOTE: All Sample Report and Product Formats in Appendix 2 are for "EXAMPLE ONLY"

TAB A (SAMPLE INCIDENT ACTION PLAN – IAP) TO APPENDIX 2 TO ANNEX N

1. Incident Name Influenza Pandemic	2. Operational Period (Date/Time) From: 11/27 0800 To: 11/27 1700	3. Documents Attached

4. IMS Position	4a. Staff Member	5. IMS Mailbox	6. Phone number
Incident Manager:	Phil Navin	IMS Incident Manager eocincidentmanager@cdc.gov	770-488-7100
Chief Health Officer	Dr. Stephen Redd	IMS Chief Health/Science Officer eocchiefhealthscienceofficer@cdc.gov	404-553-7737
Operations Section Chief	A. Ed Rouse B. Captain Ralph O'Connor	IMS Operations Section Chief eocopssectionchief@cdc.gov	404-553-7520
Planning Section Chief	A. Thomas Reynolds B. Clint Matthews	IMS CDC IMS Planning Section Chief eocplansectionchief@cdc.gov	404-553-7815
Situational Awareness Chief	Dr. Linda Neff	IMS CDC IMS SA Section Chief	404-553-7633
Logistics Section Chief	A. Toby Crafton B. Mark Hansey	IMS Logistics Section Chief eoclogsectionchief@cdc.gov	404-553-7720
Finance/Admin Section Chief	Mary MacDonald	IMS Fin & Admin Section Chief eocprocfinancechief@cdc.gov	404-553-7735
IMS JIC Lead	Von Roebuck	eocjicleadership@cdc.gov	404-202-1030
IMS Safety Official	Casey Chosewood	eocsafety@cdc.gov	404-639-2432
Duty Officer		eocreport@cdc.gov	770-488-7100

7. Current Situation/Threats: As of 0800 EDT

The first potential case of H5N1 in a human in the U.S. was reported in Atlanta, GA, yesterday by the Georgia Division of Public Health (GDPH). On Nov 25, the GDPH Laboratory Branch processed a nasopharyngeal swab specimen from a patient hospitalized at Emory Hospital. The specimen tested positive for influenza A (H5) by RT-PCR at 1037 hours on Nov 26. The GDPH has requested CDC confirmation of their findings (pending) and assistance with a case investigation initiated on Nov 26. *CLASSIFIED INFORMATION/BRIEFING IS AVAILABLE*.

8. Planning Assumptions:

1. Anticipate the test will be confirmed positive – results expected by 0900 hours today.
2. CDC must be prepared to recommend that the U.S. response level be elevated to USG Stage IV and implement strategies to impede further transmission.

9. Planning Objectives:

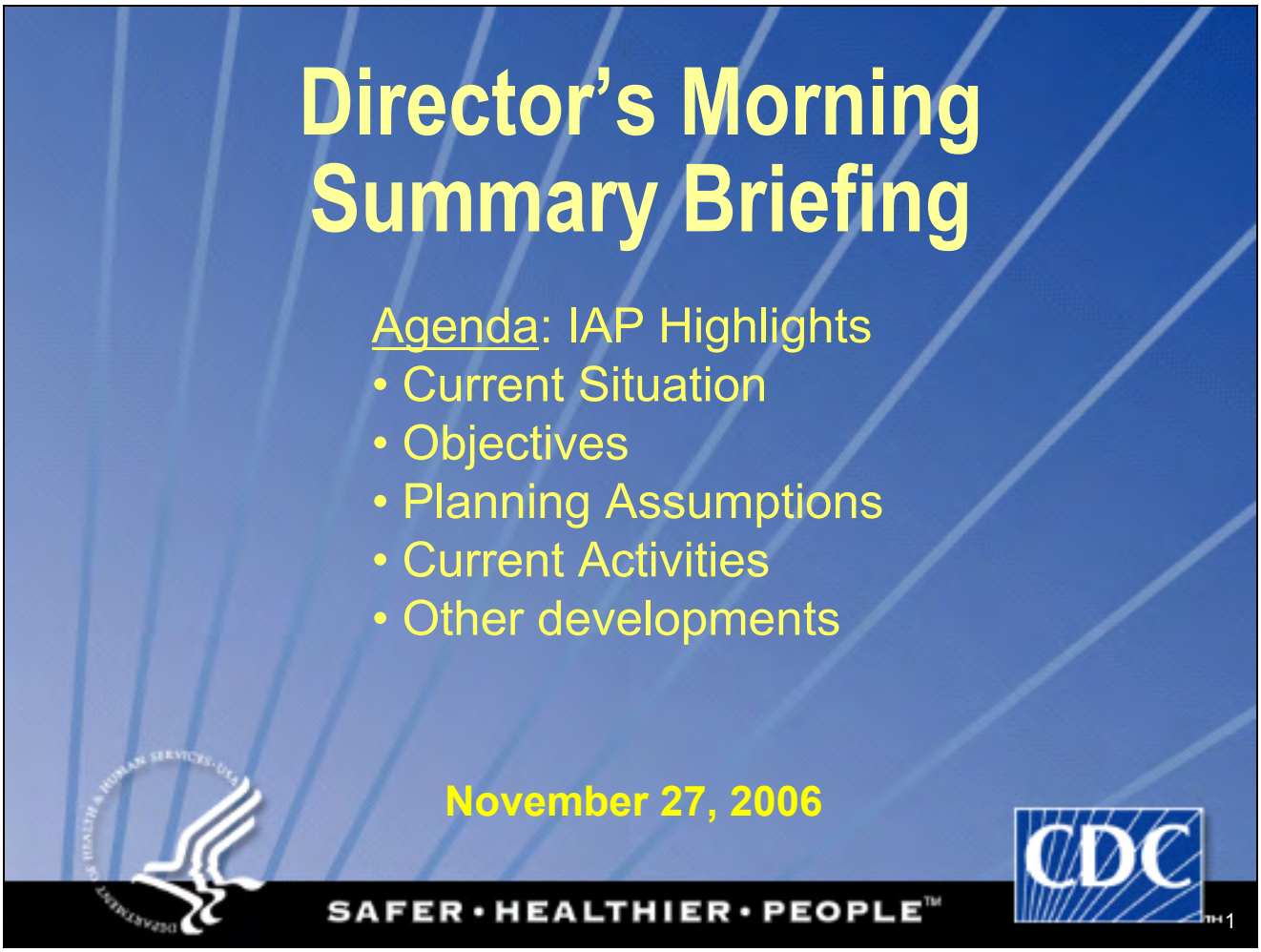
1. Prepare to activate full DEOC – identify and roster personnel.
2. Mobilize case management teams to further assist GDPH and other states, if requested.
3. Activate pandemic plans across all levels.
4. Update classified/unclassified information and event briefings.
5. Prepare to advise HHS on limiting non-essential domestic travel & increased border / port screening.
6. Plan deployment of diagnostic reagents for pandemic virus to all laboratories.
7. Plan deployment of antiviral treatments for targeted antiviral prophylaxis, as indicated.
8. Validate communications capabilities with HHS/FEMA and ensure communications with the CDC and Georgia leaders, public health, emergency management officials, and the media.

10. Work Assignment Special Instructions (if any):

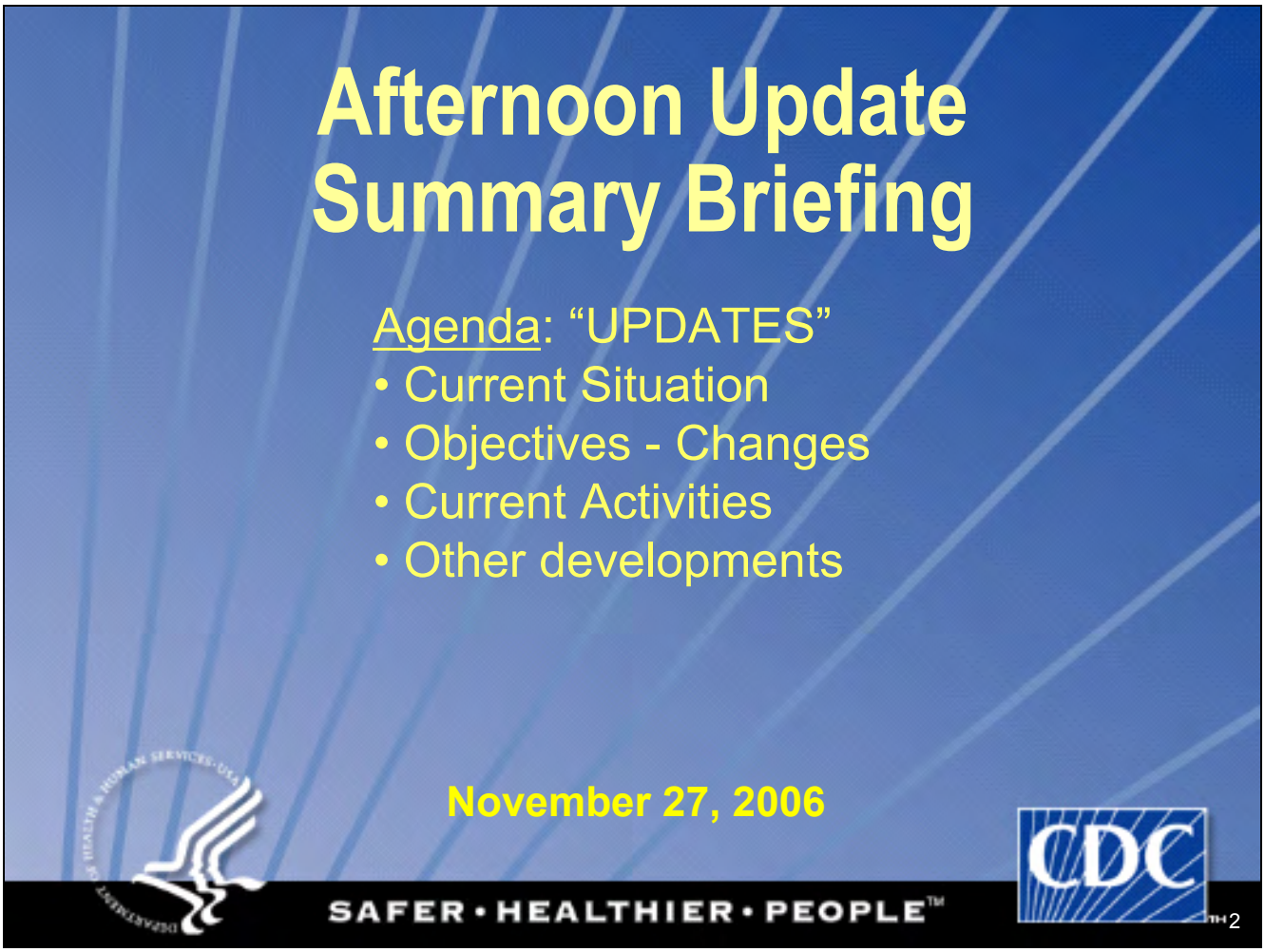
Planning Objective 1: (COTPER/OPS) Deploy team to assist GA Div of PH, in obtaining full case history and in quarantining those potentially exposed including students and hospital staff.

ICS 202 – CDC	Prepared by:

TAB B (SAMPLE DIRECTOR'S MORNING SUMMARY) TO APPENDIX 2 TO ANNEX N



TAB C (SAMPLE AFTERNOON UPDATE SUMMARY) TO APPENDIX 2 TO ANNEX N



TAB D (SAMPLE SITUATION REPORT) TO APPENDIX 2 TO ANNEX N

CDC SITUATION REPORT

1. Report Date:	2. Report Time:	3. Operational Period (Date/Time)
28 Nov 2006	1700 hours	271700 Nov 2006 to 281700 Nov 2006
4. Update on Current Situation / Threats		
5. Planning Assumptions Status / Changes		
6. Planning Objectives Status / Changes		
7. Work Assignments & Test Outcomes		
8. Status of Deployed & Pending Resources		
9. IM / Director's Narrative		

TAB E (SAMPLE SPOT REPORT) TO APPENDIX 2 TO ANNEX N

FROM: (JFO, INCIDENT NAME)

TO: DHS/IAIP/NOC

INFO: OPERATIONAL CHAIN

C L A S S I F I C A T I O N L E V E L (UNCLAS, FOUO, C, S, TS, TS/SCI)

SUBJECT: URGENT CDC SPOT REPORT

1. OCCURRENCE//

• **DATE OF URGENT OCCURRENCE**/(Date in MMDDYY Format)//

• **TIME OF OCCURRENCE**/(Time in HHMM Format)//

• **LOCATION**/(location in clearest possible short description)//

2. TYPE OF OCCURRENCE/ (In short, plain language, what happened?)//

• **RELATED TO JFO MISSIONS?**/(Yes or No—Is this directly related to the incident for which the JFO was established?)//

• **NARRATIVE**/(Describe what happened – WHO/WHAT/WHERE/WHEN/WHY/HOW.)//

3. IMMEDIATE JFO ACTION/ (Action being taken immediately by the JFO – don't wait; follow-up with a detailed SITREP later containing full details of plan of action.)//

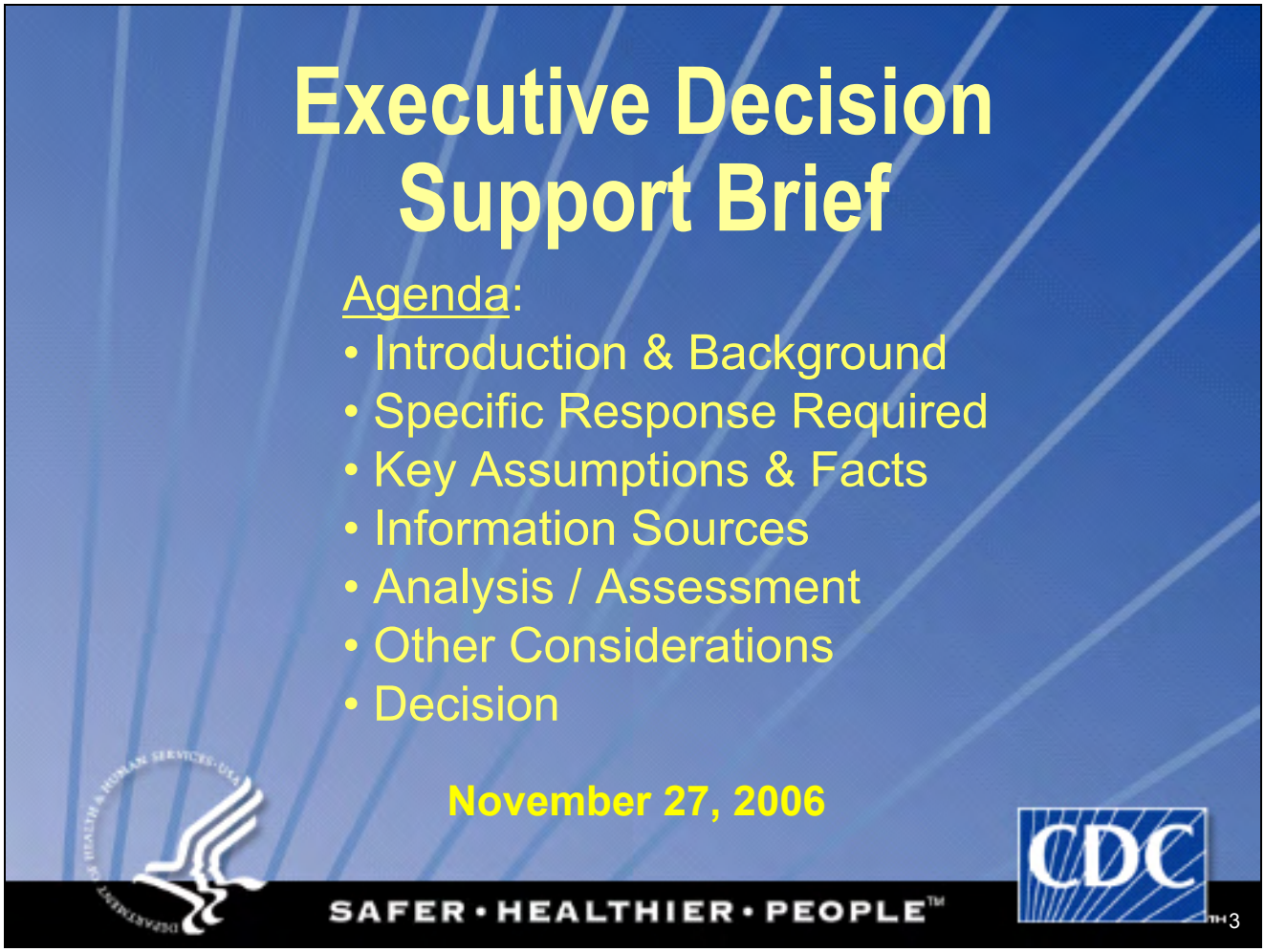
4. APPARENT TERRORISM NEXUS// (Yes or No – does the occurrence appear to have a terrorism nexus?)

5. THREATS AND CAUSAL FACTORS// (Short narrative text)

6. SPOTREP CONTACT/NAME/ Name of best POC in the JFO regarding the urgent occurrence) / (Phone number of POC) / (E-mail address of mishap POC)//

7. SPOT REPORT ###

TAB F (SAMPLE EXECUTIVE DECISION SUPPORT BRIEF) TO APPENDIX 2 TO ANNEX N



TAB G (SAMPLE EXECUTIVE DECISION SUPPORT MEMORANDUM) TO APPENDIX 2 TO ANNEX N

1. Report Date:	. 27 Nov 06	2. Operational Period (Date/time) 11/27 1700 to 11/28 1700	
3. As of Date:	. 27 Nov 06	4. From Executive Requesting Memo: Incident Manager	5. To Section Preparing Memo: Situation Awareness

6. Specific Response Required

This document is intended to support CDC executive decision to deploy CDC resources to Ukraine.

7. Key Assumptions and Facts Bearing on Issue

. .

8. Information Sources	Reliability Rate				
	Very High	High	Medium	Low	Very Low
WHO	YES				
. .		. .			
. .			. .		
. .				. .	

9. Analysis/Assessment

EXECUTIVE SUMMARY – UKRAINE, RUSSIA, EUROPE

Topic Page #

1. Executive Summary
2. Medical and Public Health Risk Assessment
   - Situational Awareness Influenza Pandemic Assessment
   - Infectious Disease Risk Assessment
   - Environmental Health Risk Assessment
   - In-country Medical Assets (hospitals, etc.)
   - Medical Countermeasures
3. Security Assessment for Ukraine
4. Recommendation/Decision
5. Where to Get Additional Web-based Information / In-country Contacts

TAB H (SAMPLE LONG TERM ANALYSIS) TO APPENDIX 2 TO ANNEX N

CDC Home | Search | Health Topics A-Z

MMWR

Weekly

June 16, 2006 / 55(23); 648-653

Update: Influenza Activity --- United States and Worldwide, 2005--06 Season, and Composition of the 2006--07 Influenza Vaccine

During the 2005--06 influenza season, influenza A (H1N1), A (H3N2), and B viruses circulated worldwide. In the United States, influenza A (H3N2) viruses predominated overall, but influenza B viruses were isolated more frequently than influenza A viruses late in the season. Influenza activity in the United States peaked in early March, and the number of pneumonia and influenza deaths did not exceed the epidemic threshold. Worldwide, influenza B viruses were the most commonly reported influenza type in Europe; influenza A (H1N1) and influenza B viruses predominated in Asia. Through June 13, 2006, outbreaks of influenza A (H5N1) viruses (avian influenza) among migratory birds and poultry flocks were associated with severe human illness or death in 10 countries (Azerbaijan, Cambodia, China, Djibouti, Egypt, Indonesia, Iraq, Thailand, Turkey, and Vietnam). This report summarizes influenza activity in the United States and worldwide during the 2005--06 influenza season and describes composition of the 2006--07 influenza vaccine.

c) United States

The national percentage of respiratory specimens testing positive for influenza and the proportion of outpatient visits to sentinel providers for influenza-like illness (ILI)* peaked in early March 2006. Influenza A (H3N2) viruses were most commonly isolated overall, but influenza B viruses were more frequently identified than influenza A viruses during late April and May. A small number of influenza A (H1N1) viruses also were identified.

d) Viral Surveillance

During October 2, 2005--May 20, 2006, World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System collaborating laboratories in the United States tested 139,647 specimens for influenza viruses, and 17,414 (12.5%) were positive (Figure 1). Of these, 14,093 (80.9%) were influenza A viruses, and 3,321 (19.1%) were influenza B viruses. Among the influenza A viruses, 5,661 (40.2%) were subtyped; 5,231 (92.4%) of those were influenza A (H3N2) viruses, and 430 (7.6%) were influenza A (H1N1) viruses. The proportion of specimens testing positive for influenza first exceeded 10% during the week ending December 24, 2005 (week 51), peaked at 23.0% during the week ending March 11, 2006 (week 10), and declined to <10% during the week ending April 29, 2006 (week 17), for a total of 18 consecutive weeks during which more than 10% of specimens tested positive. Peak percentage of specimens testing positive for influenza ranged from 23.2% to 41.0% during the preceding five influenza seasons, and the peak occurred during early December to late February ([1]; CDC, unpublished data, 2006). Also during the preceding five seasons, the number of consecutive weeks during which more than 10% of specimens tested positive for influenza ranged from 11 to 15 weeks (CDC, unpublished data, 2006).

TAB I (SAMPLE TRAVEL SUMMARY) TO APPENDIX 2 TO ANNEX N

Travelers' Briefing Health Notice

Outbreak Notice
Human Infection with Avian Influenza A (H5N1) Virus
Advice for travelers

This information is current as of today, September 14, 2006, 08:59:36 AM

This notice initially released: September 23, 2005

Avian influenza A (H5N1) viruses usually affect wild birds but have infected and caused serious disease among poultry, such as chickens. Human infections with H5N1 viruses are rare, but have also occurred in several countries since 2003. For a current list of countries reporting outbreaks of H5N1 virus infection among poultry and/or wild birds, view updates from the World Organization for Animal Health (OIE). Cumulative numbers of confirmed human cases of avian influenza A (H5N1) by country are available on the World Health Organization (WHO) Avian Influenza website. An assessment of the current situation can be found on the Centers for Disease Control and Prevention (CDC) Avian influenza website.

PandemicFlu.gov
Get Informed. Be Prepared.
visit the official U.S. government website for pandemic influenza

Most cases of H5N1 influenza in humans are thought to have occurred from direct contact with infected poultry in affected countries. Contact with sick or dead poultry as well as with poultry that have no apparent symptoms should be avoided. Contact with surfaces that may have been contaminated by poultry feces or secretions should also be avoided. Transmission of H5N1 viruses to two persons through consumption of uncooked duck blood may also have occurred in Vietnam in 2005. Uncooked poultry or poultry products, including blood, should not be consumed.

CDC remains in communication with WHO and continues to closely monitor the H5N1 situation in countries reporting human cases and outbreaks among birds.

The public health threat of a pandemic arising from novel influenza subtypes such as influenza A (H5N1) will be greatly increased if the virus gains the ability to spread from one human to another. Such transmission has not yet been observed. However, a few cases of limited person-to-person spread of H5N1 viruses have been reported, with no instances of transmission continuing beyond one person.

H5N1 infections in humans can cause serious disease and death. A vaccine to protect humans against influenza A (H5N1) is not yet available, but a candidate vaccine is undergoing human clinical trials in the United States. The H5N1 viruses currently infecting birds and some humans are resistant to amantadine and rimantadine, two antiviral medications commonly used to treat influenza. Most of the H5N1 viruses tested have been susceptible to the antiviral medications oseltamivir (Tamiflu®) and zanamivir (Relenza®), but resistance has been reported. The effectiveness of these drugs when used for treatment of H5N1 virus infection is unknown. For more information about influenza antiviral drugs, see http://www.cdc.gov/flu/avian/gen-info/avian-flu-humans.htm#antiviral

TAB J (SAMPLE MEDIA UPDATE TEMPLATE) TO APPENDIX 2 TO ANNEX N

Example Update on Multi-State Outbreak of E. coli O157:H7 Infections From Fresh Spinach, October 6, 2006

Contact CDC

- 800-CDC-INFO
  888-232-6348 (TTY)
  cdcinfo@cdc.gov
- Report a Food borne Illness

NOTE: *This is the last planned Web update for this outbreak.*

As of 1 PM (ET) October 6, 2006, Friday, 199 persons infected with the outbreak strain of *E. coli* O157:H7 have been reported to CDC from 26 states.

Among the ill persons, 102 (51%) were hospitalized and 31 (16%) developed a type of kidney failure called hemolytic-uremic syndrome (HUS). One hundred forty-one (71%) were female and 22 (11%) were children under 5 years old. The proportion of persons who developed HUS was 29% in children (<18 years old), 8% in persons 18 to 59 years old, and 14% in persons 60 years old or older. Among ill persons who provided the date when their illnesses began, 80% became ill between August 19 and September 5. The peak time when illnesses began was August 30 to September 1 -- 31% of persons with the outbreak strain became ill on one of those 3 days.

Three deaths in confirmed cases have been associated with the outbreak. One was in an elderly woman from Wisconsin. Yesterday, Idaho confirmed that stool samples from a 2-year-old child with HUS who died on September 20 contained *E. coli* O157 with a "DNA fingerprint" pattern that matches the outbreak strain. Today, Nebraska reported the death of an elderly woman with an illness compatible with *E. coli* O157 infection who consumed raw spinach; *E. coli* O157 with the outbreak strain "DNA fingerprint" was detected in the remaining spinach.

Maryland is investigating a suspect case in an elderly woman who died on September 13 and had recently consumed fresh spinach. *E. coli* O157 was cultured from her stool, but "DNA fingerprinting" has not been possible.

TAB K (SAMPLE SURVEILLANCE DATA REPORT TEMPLATE) TO APPENDIX 2 TO ANNEX N

TO BE PUBLISHED

TAB L (SAMPLE FIELD REPORT TEMPLATE) TO APPENDIX 2 TO ANNEX N

FIELD REPORT TEMPLATE Send this report to fieldteam@cdc.gov	
NAME OF OFFICIAL OR TEAM LEADER REPORTING:	
LOCATION AND CONTACT INFORMATION:	
REPORTING PERIOD / REPORT # :	
SUMMARY OF MISSION/ OPERATIONAL ACTIVITIES/ OBJECTIVES:	
IDENTIFY PUBLIC HEALTH REPORTS AND DATA SETS FORWARDED TO CDC:	
SPECIFIC REQUESTS FOR IMMEDIATE ASSISTANCE/ POTENTIAL MISSION ASSIGNMENTS (next steps):	
DESCRIBE TODAY'S COORDINATION WITH LOCAL/STATE PUBLIC HEALTH SERVICES, DHHS FIELD STAFF and OTHER FEDERAL AGENCIES:	
DESCRIBE CDC FIELD TEAM ACTIVITIES COMPLETED TODAY:	
ADDITIONAL INFORMATION – ACHIEVEMENTS – SUCCESSFUL OUTCOMES:	
ANTICIPATED / EMERGING PUBLIC HEALTH ISSUES IN REGION (Not already Reported):	
UN-MET TEAM REQUIREMENTS / BARRIERS / PROBLEMS: A. Logistical needs (include status of PPE & Supplies): B. Resilience and mental health concerns: C. Safety concerns: D. Austere Conditions (Living or Working): E. Anticipated Staff Changes (next 48 hours)	
F. Other concerns:	
EXTRA SPACE FOR ADDITIONAL TEAM INFORMATION:	
REPORT OF ILLNESS / INJURY IN THIS TEAM: •	
PROJECTED AFFECT ON CONTINUITY OF OPERATIONS / STATUS OF COOP READINESS: •	
SUBMITTED BY:	